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No. 85-1385

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA,

Petitioner,

v.

GENERAL DYNAMICS CORPORATION, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

Was the taxpayers' liability at the end of 1972 for employee medical benefits for medical services received by their employees in 1972 fixed and certain for the purposes of the "all events" test, as both the trial court and the appellate court held, and therefore deductible on the accrual basis in 1972?

PARTIES TO THE PROCEEDING

In addition to the party named in the caption, General Dynamics Land Systems, Inc. (formerly called Stromberg-Carlson Corporation), DatagraphiX, Inc., Material Service Corporation and Marblehead Lime Company are respondents. They are subsidiaries of General Dynamics Corporation.

STATEMENT REQUIRED BY RULE 28.1

Respondents have the following affiliated corporations, companies and partnerships: Mansour-G.D. Ltd.; Mines SNA, Inc./SNA Mines, Inc.; Etudes Techniques et Constructions Aerospatiales, S.A.; Tusas Aerospace Industries, Inc.; and Continental Cement Company. Respondents have no other parent corporation and no other subsidiary which is not wholly owned.

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BRIEF FOR RESPONDENTS

STATEMENT OF THE CASE

The issue in this case is the proper timing for the deduction by these accrual-basis taxpayers of their liability for medical benefits received by their employees.

Since October 1972, taxpayers have directly provided regular medical benefits to their employees and their employees' dependents. (J.A. 18, 20, 81-83, 85.)* At the end

* References are as follows: "Pet. App." refers to the Appendix to the Petition for a Writ of Certiorari; "J.A." refers to the Joint Appendix; "PX" refers to Plaintiffs' Trial Exhibit; "Tr." refers

(Footnote continued on following page)

of 1972, the taxable year at issue, the taxpayers had not actually paid for all of the medical services received by their employees during 1972. This occurred because there is a lag in time between the receipt of medical services by the employee and the actual payment for those services by taxpayers. (J.A. 26.) At year-end, there were employee claims for 1972 benefits which had not yet been filed and other 1972 claims which had been filed and were being processed. (J.A. 26.) Because taxpayers were on the accrual basis, they accrued the expense for these unpaid 1972 medical benefits on their books. (J.A. 18, 27-28.)

These medical benefit expenses are ordinary and necessary business expenses of the type which are clearly deductible. (J.A. 19.) Thus, the issue is one of timing: must these expenses for medical services received by employees in 1972 be deducted in 1972 or must they be deducted in a later year. The proper timing for a deduction by accrual-basis taxpayers is governed by the "all events" test of Treasury Regulation § 1.461-1(a)(2). Under that test, a liability must be deducted in the year in which all events have occurred which determine the fact of liability.* Actual payment of an expense by year-end is not required. (J.A. 18.)

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footnote continued

to the trial transcript; "Pet." refers to the Petition for a Writ of Certiorari; "Pet. Br." refers to Petitioner's Brief on the merits. PX 1 through 10 and PX 13 through 46 were offered at Tr. 31-40 and received in evidence at Tr. 40-41. PX 47 was offered at Tr. 41-42 and received in evidence at Tr. 43.

* The "all events" test has a second element which must also be satisfied: the amount of the liability must be determinable with reasonable accuracy. Both lower courts in this case concluded that the second element (as well as the first) had been met. (Pet. App. 1a, 4a-5a, 16a-17a.) The government deliberately did not seek review of the "amount" issue. (Pet. 13 n.2; Pet. Br. 33 n.10.) Consequently, that issue is now foreclosed, and the government's direct and indirect discussion of the "amount" issue should be disregarded.

In determining whether the events establishing the fact of liability have occurred, it is necessary to focus on whether, immediately following the employee's receipt of medical services, the combination of then existing facts concerning (1) his employment status, (2) the nature of the medical services received and the amount charged for them, and (3) the provisions of the medical benefit plans and the standards used in processing claim forms rendered taxpayers' liability for those medical benefits definite and certain, rather than leaving it contingent or contested.

The Factual Record. Despite the fact that the government seeks, in effect, to have this Court set aside the trial court's findings of fact, which were affirmed by the Court of Appeals, it does not describe the evidence or attempt to demonstrate that the findings are "clearly erroneous." Instead, the government states its own general assumptions about the nature of medical benefits and then argues as though these assumptions were the facts adduced at trial.

However, there is a detailed factual record in this case. In addition to a stipulation as to many matters (J.A. 17-38), taxpayers presented a substantial number of exhibits and the testimony of five witnesses. Three of the witnesses testified specifically about the facts relevant to the issue now before this Court. Those three witnesses were: James A. Hawkins, the Director of Employee Benefits from 1970 to 1980, who was in charge of taxpayers' medical benefit programs, including the design and administration of the plans (J.A. 81-83); J. David Loftus, an administrator in the Group Claim Department of The Aetna Life Insurance Company ("Aetna"), who had 23 years of extensive experience in claims processing and group medical benefit plan administration (J.A. 100-103); and C. Robert Schaal, manager and senior claim consultant of the Group Health Claim Administration Division of The Prudential Insurance

Company of America ("Prudential"), who had 23 years of extensive experience in claims processing and administration of medical benefit plans in general and the taxpayers' plans in particular (J.A. 142-145).* The complete testimony of these three witnesses is contained in the Joint Appendix (J.A. 81-176). The government offered no witnesses, but introduced some documents relating to the plans.

The examination of these three witnesses and the content of many of the exhibits focused precisely on the nature and provisions of the taxpayers' medical benefit plans and the standards and procedures by which they were administered. This evidence provided a specific factual basis for determining whether claims processing was ministerial and uncontested (as taxpayers assert), or uncertain, discretionary and contested (as the government suggests). After hearing the evidence, the trial court found that taxpayers' liability attached upon the receipt of medical services by their employees and did not await the completion of the routine and clerical processing of the claim forms for payment. (Pet. App. 11a-13a, 15a.)

The Medical Benefit Plans. The evidence showed that the plans provided basic medical benefits and major medical benefits. (J.A. 21, 82-83, 105-106, 145-146.) The basic medical benefits included hospital costs (primarily room and board charges), doctors' fees for surgery, costs for anesthesia and other medical services. The basic plan paid 100% of covered items up to specified and pre-established limits (*e.g.*, $60 per day for a hospital room; $200 for an

* Aetna and Prudential have administered the plans ever since taxpayers took over direct liability for the medical benefits in 1972. (J.A. 20-21; PX 4; PX 5.)

appendectomy) without a deductible.* (J.A. 48-52, 63-77, 83, 105.) The major medical benefits provided for costs exceeding those covered by the basic medical plan, as well as certain additional items (*e.g.*, prescription drugs). The major medical plan had an annual deductible (typically $100) and then paid for costs on a shared basis (typically, taxpayers paid 80% and the employees, 20%). (J.A. 52-54, 64-65, 106.) Each plan described in detail the persons covered and the exact nature and extent of the benefits provided. (J.A. 21, 48-77; PX 40; PX 5, pp. 13-217.)**

Taxpayers provided these medical benefits to their employees as part of the consideration for the employees' services. (J.A. 18.) Taxpayers promised their employees that the benefits provided by the plans would be paid. (J.A. 19.) Booklets describing the plans were distributed to all of the employees so the employees were fully informed of the benefits to which they were entitled. (J.A. 22, 48-77, 85-86; PX 40.) Taxpayers' liability for the medical benefits was a matter of contract; liability did not depend upon any determination that the need for the benefits resulted from anyone's fault or wrongdoing. (J.A. 25.)

Under the plans, taxpayers' general contractual liability to provide benefits became fixed as to particular medical expenses of a specific employee at the time the medical services were received by that individual. (J.A. 87.) At

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* For example, the plan described in Plaintiffs' Exhibit 9 (J.A. 48-77) states that the basic medical plan will pay actual hospital room and board expenses up to a maximum rate of $60 per day for 365 days. (J.A. 63.) It states that other hospital costs (such as an operating room charge) will be paid up to a total of $800. (J.A. 48, 63.) The plan has an extensive schedule of the amounts it will pay for specific surgical procedures. (J.A. 66-76.)

** One plan, Plaintiffs' Exhibit 9, is set forth in the Joint Appendix (pages 48-77); another is Plaintiffs' Exhibit 40. Both plans are typical of taxpayers' medical benefit plans. (J.A. 22.)

that time, all conditions to the liability had occurred and been satisfied: (1) the person receiving the services was covered under the plan, (2) the services were covered under the plan, and (3) the services had been performed. At that time, the employee had a vested right to payment of his benefits according to the amounts specified in the plan.

All witnesses testifying on the subject agreed that under the provisions of taxpayers' plans, the critical time for fixing the liability for specific benefits was when the services were received, not when claims for payment were filed and/or processed. Once services had been received while the plan was in effect, taxpayers could not avoid liability for those services by terminating the plans prior to the filing or complete processing of a claim. (J.A. 87-88, 133-34.) Similarly, termination of an employee's employment would not extinguish taxpayers' liability for services received prior to such termination of employment, even if the claim form was filed afterwards. (J.A. 87, 133, 172-173.)

Processing of Claim Forms. To obtain payment for medical services received, employees submitted claim forms, which underwent a routine, standardized processing procedure and were paid according to the benefit schedules contained in the plans. (J.A. 23, 88-89, 106-110, 149-154.) In filing claim forms, employees submitted the raw data, such as doctor's and hospital bills. (J.A. 23; PX 10.) The amount of reimbursement to which employees were entitled under the plans was calculated by claims processors. (J.A. 23-24, 89.)

A simple clerical check was made to verify that the person receiving services was covered (that is, that he was employed and had satisfied any applicable waiting period if he was a new employee) at the time of treatment. (J.A.

23, 89-90, 149-50.) The forms were then processed by matching the claim data against the plan provisions to calculate and pay the amounts due. (J.A. 23-24, 88-89, 107-110, 150-152.) The benefit calculations were made by experienced claim processors who were familiar with taxpayers' plans. (J.A. 23-25, 107-108, 148-149.) They followed the very detailed provisions and schedules of the plans, which were augmented by guidelines and routine procedures established by Aetna and Prudential.* (J.A. 25, 108-109, 112-116, 152-153, 157, 160.) The processors excluded amounts which were not covered at all (such as a hospital meal for a patient's guest and television rental charges on hospital bills), calculated the basic medical benefits, and then calculated the major medical benefits.** (J.A. 107-110, 151-154.) Approximately 95% of the claims were handled by the regular processors and only 5% required consideration by more experienced supervisors—still in a routine manner. (J.A. 111-112, 154-155.)

The government seems to suggest (Pet. Br. 3) that application of plan provisions to situations which happen to involve preexisting conditions, prevailing rates, work-related conditions, and services not reasonable and customary is difficult and problematical. However, Messrs. Loftus and Schaal described in detail how these matters were handled in a routine fashion. Briefly, the evidence on these matters was as follows:

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* Aetna's claims processors typically were women, twenty years of age, high school graduates with one year of college or business experience. (J.A. 104-105.)

** In most instances, all necessary data was contained in the papers when the processors received them. In those instances where additional data was necessary, rather than reject the claim, the missing data was obtained, usually by telephone or letter to the employee, doctor or hospital, as the case might be. (J.A. 23, 121, 163-164.) Then the processing would be completed.

Preexisting conditions applied only to new employees and only to certain types of their claims (*e.g.*, chronic conditions like gall bladder problems). Taxpayers' plans paid medical benefits for preexisting conditions unless the employee had received medical treatment for the particular condition within ninety days prior to the effective date of coverage. In the small number of claims involving new employees where the claim suggested a preexisting condition, the necessary information was on the claim form or was collected by a routine telephone call or letter. The information easily established whether the condition was treated in the ninety-day period. If not, payment was made. (J.A. 128-130, 162-163.)

As to excessive charges for services, Prudential and Aetna maintained surgical profiles or printouts showing the levels of charges being made by physicians in a locality for a particular surgical procedure. Prudential paid physicians' bills that fell in the 90th percentile category of charges for that particular procedure (*i.e.*, 90% of the bills of local physicians fell at or under that level). Aetna paid these at or below the 85th percentile. Processors merely had to compare the amount of the bill with the appropriate percentile line on the printout. Before refusing to pay part of a physician's bill which exceeded the applicable percentile, a call was made to ascertain whether complications not disclosed on the claim form justified the higher charge. (J.A. 113-116, 160-161.)

The claim form and taxpayers' records reporting injuries on the job showed whether the claim resulted from a work-related injury or illness covered by workmen's compensation. Consequently, these claims were sorted out on a routine basis. (J.A. 98-99, 170-171.)

Claims processors were supplied with detailed lists of types of covered and non-covered services and expenses and guidelines for expected durations of hospital confine-

ment for particular surgical procedures. Generally, these lists immediately established which services and expenses were covered and which were not. If the length of the hospital stay exceeded these routine guidelines, the employee's physician was contacted to ascertain whether there had been medical complications not shown on the claim form. (J.A. 25, 108-109, 112-116, 119-121, 152-154, 157, 160.)

Once claims were processed, checks were prepared and issued for the payment of the benefits which were due. An explanation sheet was sent to each employee explaining the calculation of the benefit amount and which items were not covered by the plan and thus not paid. (J.A. 25, 89, 109-110, 134, 151-152.)

Nonexistence of Disputes. Disputes regarding medical benefit payments were virtually nonexistent. (J.A. 25-26, 90-91.) By their very terms, the plans did not purport to pay 100% of all medical costs: the basic medical plan provided for specific amounts and the major medical plan shared the costs on an 80/20 basis after applying a specific deductible. (J.A. 83-84, 169-170; see J.A. 48-77 and PX 40.) Employees did not themselves calculate the amount due; instead, they submitted all their medical bills, and the processors made the calculations. (PX 10; J.A. 23-24.) Consequently, nonpayment of items not covered by the plans did not reflect the "denial of claims" and did not cause disputes. Experience shows that in the aggregate, 90% of total medical costs were covered by the plans and thus paid. The 10% of total medical costs which were, on the average, not covered by the plans were, of course, not paid.* (J.A. 91.) In effect, 100% of covered costs were paid.

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* Most of the 10% of non-paid costs derive from the fact that the major medical plans generally call for the employer to pay 80% of the excess over the basic medical payment plus a deductible. (J.A. 52, 64, 92.)

Furthermore, the philosophy applied in processing the claims under the plans was to pay everything which was due. Taxpayers were interested in promoting good employer-employee relations, not in causing discord and disaffection. (J.A. 92-93, 123, 173.) Mr. Hawkins, taxpayers' Director of Employee Benefits, testified that he could recall no lawsuits regarding medical benefits in the 10-year period from 1970 to 1980. (J.A. 91.) This was supported by Mr. Schaal of Prudential, who testified that he could recall only two lawsuits regarding taxpayers' medical benefit plans in the period from 1969 to 1983.* (J.A. 171-172.)

Background of this Litigation. At year-end 1972, taxpayers determined the amount of their liability for unpaid medical services which had been rendered in 1972. (J.A. 18, 26-32.) This amount was accrued as a liability on their books. (J.A. 18, 26-32.) It did not include any provision for medical costs not covered by the plans, disputed claims, or medical services to be rendered in later years. (Tr. 146-147, 228-229.) The majority of the unsubmitted claims for 1972 medical services were submitted in the first few months of 1973. (J.A. 93.) Of the $4,583,893 paid in 1973 and 1974 for medical services received in 1972, all but $80,279 was paid in 1973. (J.A. 35.)

After considering the evidence, the Claims Court rejected the government's view that, under the "all events" test. taxpayers' liability was not fixed until claims had

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* This absence of disputes concerning the taxpayers' medical benefit plans was corroborated by the insurance companies' own general experience. Aetna had only 129 lawsuits in 1979 when it made over 16,000,000 medical benefit payments and only 199 lawsuits in 1982 when it made over 33,000,000 payments. (J.A. 134-135.) Prudential had 96 lawsuits in 1982 in relation to 450,000,000 medical benefit payments. (J.A. 172.)

been filed and processed. Instead, based on substantial evidence regarding the plans and how processing actually operated, the Claims Court found that the processing was routine, clerical and ministerial, and that taxpayers' liability was sufficiently fixed and certain so as to satisfy the "all events" test. (Pet. App. 7a, 11a-15a, 17a-18a.) The Court of Appeals for the Federal Circuit affirmed. (Pet. App. 1a, 5a.)

SUMMARY OF ARGUMENT

Since 1926, the standard for determining when an accrual-basis taxpayer's expense is to be regarded as "incurred" for federal income tax purposes has been the "all events" test. *United States* v. *Hughes Properties, Inc.*, ____ U.S. ____, 106 S.Ct. 2092, 2096 (1986); *United States* v. *Anderson*, 269 U.S. 422, 440-41 (1926); Treasury Reg. § 1.461-1(a)(2). The sole issue before this Court is whether the lower courts were correct in concluding that taxpayers' deduction for accrued medical benefit expenses satisfied the first prong of the "all events" test, *i.e.*, that by year-end 1972, all events had occurred which established the fact of liability.

The government addresses the merits of this critical issue beginning at page 30 of its brief. The preceding portion of the government's brief is devoted to irrelevant arguments and contentions that expense deductions by accrual-basis taxpayers should be viewed with skepticism. However, this Court and the lower federal courts have taken a much more realistic view. In cases in which the taxpayer's liability was contested or was contingent upon the occurrence of future events, this Court has denied the attempted deduction. On the other hand, when the facts

demonstrated the existence of a present, fixed liability, this Court has upheld the deduction notwithstanding efforts by the government to conjure up hypothetical circumstances in which payment of the obligation conceivably might not occur.

Confronting the issue in this case evenhandedly and with due regard to the findings of the Claims Court which were affirmed by the Court of Appeals, the outcome is clear. The uncontradicted evidence established that taxpayers' liabilities at the end of 1972 for medical benefits to employees who had received medical services but had not yet been paid were definite and certain, rather than contested or contingent.

The government ignores or glosses over both the uncontroverted trial evidence and the trial court's findings of fact; but this is clearly improper. The evidence established the extremely specific terms of the medical benefit plans with respect to how much would be paid for specific types of hospital confinements and particular medical and surgical procedures. Experienced claim handlers testified to the standard and routine procedures by which claims forms were processed—in effect, matching up the employees' expenses with the detailed provisions of the medical benefit plans. Virtually all of the claims were processed by clerical employees on a volume basis in accordance with routine procedures. Only a very small number of claims raised problems, and contests regarding medical benefit claims were virtually nonexistent. Consequently, once the employee had received specific medical services, the taxpayers' liability to that employee matured and became fixed according to the detailed provisions of the plans. After rendition of these medical services, neither termination of employment nor termination of a medical benefit plan could defeat taxpayers' existing liability to that employee.

The government argues that liability is not fixed until claim forms are filed and processed. The evidence and the findings of the trial court contradict the government's factual argument, and it is equally baseless as a matter of law. There is no evidence that any significant number of employees failed to file claim forms. In any event, failure to file a form is merely the equivalent of a waiver of an already vested right to payment. In the case of any fixed, accrued liability, the creditor or obligee may waive payment when the time comes. Therefore, acceptance of the government's argument that the possibility of waiver prevents fixation of liability would prevent the deduction of any unpaid expense. That is not the law.

As to processing, the evidence demonstrates that because of the detailed nature of the medical benefit plans and the processing routines, processing of claim forms is a routine, ministerial exercise of matching employee bills against benefit provisions. The cases, including *United States* v. *Anderson, supra*, the seminal "all events" test case, establish that the necessity for the processing of routine paperwork does not delay fixation of liability for purposes of the "all events" test.

The government asserts that liability is not fixed because at year-end taxpayers do not know the names of many of the employees who have received medical services and estimated the amount of their liability on an "aggregate" basis. However, this does not alter the fact that taxpayers had by year-end 1972 incurred liability in specific amounts to particular individuals who had, in fact, received actual medical services. In an analogous situation, this Court recently rejected the government's argument that lack of identification of a winning slot machine player prevented fixation of liability for progressive jackpots. *United States* v. *Hughes Properties, Inc.*, 106 S.Ct. at 2097. Furthermore, the government's objection to a so-

called "aggregate" method of calculation is relevant, if at all, to satisfaction of the second prong of the "all events" test, that the amount of the liability must be determinable with reasonable accuracy. But that issue is foreclosed because the government deliberately chose not to present it for review in this Court, correctly characterizing it as a purely factual question not warranting review. (Pet. 13 n.2; Pet. Br. 33 n.10.)

The bulk of the government's argument is made up of distractions and red herrings about reserves, financial accounting and insurance companies. Reserves can be created for any unpaid liability ranging from the most contingent and hypothetical to the most fixed and definite. Consequently, the presence or absence of a reserve is irrelevant, and the method by which it is calculated concerns only the "reasonable accuracy" prong of the test. There is no evidence in the record concerning financial accounting, and taxpayers have never sought to justify their deduction on the basis of financial accounting. Thus, the accounting argument is also irrelevant. Finally, taxpayers have never asserted that they are insurance companies, nor have they sought to justify their deduction by using the special tax provisions relating to insurance companies. Taxpayers who satisfy the "all events" test are entitled to a deduction, regardless of whether or not insurance companies could take deductions in similar circumstances.

The trial evidence, the findings of the lower courts and existing law establish that taxpayers have satisfied the "all events" test and that the lower courts' decisions should be affirmed.

ARGUMENT

I. THE "ALL EVENTS" TEST IS SATISFIED BY THE RECEIPT OF MEDICAL SERVICES BY EMPLOYEES IN 1972.

The first part of the "all events" test is that all events must have occurred which determine the fact of liability. Treasury Reg. § 1.461-1(a)(2). Under this test, a deduction is allowed when a liability is fixed and certain, *United States* v. *Anderson*, 269 U.S. at 440-41; *United States* v. *Hughes Properties, Inc.*, 106 S.Ct. at 2096; and denied when liability is either contingent or contested by the taxpayer, *Brown* v. *Helvering*, 291 U.S. 193, 200 (1934); *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516, 519 (1944).

The "all events" test has been interpreted in a practical manner: when the facts establishing liability have occurred, a deduction is proper even though technical procedures or paperwork required for payment have not yet been completed. *United States* v. *Anderson*, *supra*. As discussed below, the courts have repeatedly rejected the government's arguments that liability is not fixed until the time has come for payment of the obligation. To do otherwise would be to reject the accrual method of accounting and put everyone on the cash basis. The most recent rejection of the government's argument by this Court was last term in the *Hughes Properties* case, *supra*.

A. The Trial Court's Findings Of Fact Control This Case.

At the outset, it must be noted that the government improperly attempts to avoid the findings of fact and evidence in this case. It largely ignores the evidence and relies on its conjectures regarding medical benefits. But

taxpayers developed an extensive factual record regarding the medical benefit plans and claims processing, and based on evidence which withstood cross-examination, the trial court found for taxpayers. Thus, the government's suggestions and conjectures that claims processing is difficult and problematical, that people do not file claims, and that claims are contested must be rejected. The evidence and the findings are to the contrary: claims processing is clerical and ministerial (Pet. App. 11a-12a), claims are not contested (Pet. App. 12a-13a), and there is no evidence that any substantial number of people do not file claims. The evidence adduced by taxpayers and the findings of the trial court regarding the medical benefits plans and how they actually worked must be accepted. They are not clearly erroneous (indeed, the government does not attempt to show they are), and therefore are not subject to review by this Court. See *Berenyi* v. *District Director, Immigration and Naturalization Service*, 385 U.S. 630, 635-36 (1967); *Anderson* v. *Bessemer City*, 470 U.S. 564 (1985).

B. Liability Was Fixed When The Medical Services Were Received.

Taxpayers clearly satisfy the first part of the "all events" test: the liability for medical services which had been received was fixed and definite at the end of 1972, and was not contingent. The medical benefit plans were in existence and were quite specific regarding who was covered, what was covered, and what would be paid. Taxpayers had contractually obligated themselves to pay for the covered medical services received by covered employees. While prior to receipt of medical services, the plans merely represented potential or contingent liabilities for taxpayers to their employees at large, when the employee received actual medical services, the event which established taxpayers' specific liability to that specific

employee occurred. At that time, the employee was or was not covered by the plan; the medical services were received; and the plan specified the type and amount of benefits. Taxpayers' liability for those services had ripened; that liability was contingent no longer. The situation is like that of a simple contract. If A offers to pay B $500 provided B moves to Pittsburgh, the offer becomes irrevocable and B becomes entitled to the $500 as soon as he moves to Pittsburgh, even though he does not notify A at the time of the move.

The critical nature of the time at which medical services were received is demonstrated by several facts. Once services were received, subsequent termination of the plans would not terminate liability for the prior medical services. If an employee's employment ceased, taxpayers still had to pay for medical services received prior thereto. Once services were received, taxpayers could not choose to reduce the level of benefits and pay less than the amounts provided in the plans. Liability existed regardless of whether the claim form had been filed and/or processed before plan termination or termination of employment.

Thus, as the trial court properly held, once the medical services were received, the underlying liability was fixed; the fact of liability was established. (Pet. App. 11a-15a.)

C. Speculation That Some Employees Might Not File Claim Forms Does Not Make The Liability Contingent.

The government places great emphasis upon the fact that many of the employees who received medical services in late 1972 had not yet filed claim forms by the end of the year. The government speculates that some employees might never file claim forms through inadvertence, or because the amount is too small to bother with,

or conceivably because they might wish to conceal the nature of an illness from their employer.

First of all, the notion that some significant number of employees might fail to file claim forms to collect their medical benefits is, like most of the government's "factual" arguments, pure conjecture. There was no evidence that employees in fact failed to file claim forms. The evidence showed that each employee was given a booklet describing the medical plans so employees knew they were entitled to these benefits. (J.A. 22, 48-77.) Filing claims was not difficult; the employee presented raw data and did not have to calculate the amount covered by the plan. (PX 10.) Mr. Schaal testified that he did not understand why an employee would not file a claim, particularly since he would be dunned to pay the medical bills. (J.A. 176.) Hospitals generally sent their bills directly to taxpayers, who would inquire of the employee if a claim form covering that hospitalization was not turned in. (J.A. 150, 175.) It is exceedingly unlikely that employees would forego payment of items of significant amount.

Even assuming *arguendo* that some few employees do not claim their benefits, this would not negate the earlier existence of a fixed and definite obligation. Analytically, the failure of an employee to file a claim form amounts to a waiver of an already accrued right to benefits. Any obligee may decline or waive payment of any obligation, no matter how fixed or certain. The possibility of such waiver does not mean that the obligation never existed or was not fixed or certain. Otherwise, no accrued expense could ever be deducted because the possibility of waiver by the obligee would always exist at any time prior to payment.

A few examples will illustrate the point. An employee completes a week's work and has earned his pay for that

week. There is a possibility that he may fail to pick up his paycheck or take the check, misplace it and never cash it. Does that mean that there was no fixed obligation to pay his wages? Of course not. An employee who has spent three days in the hospital and is covered by a medical benefit plan authorizing $60 per day in benefits for the hospital room is no less definitely entitled to that money than he is to his pay for his last week's work. Alternatively, look at an example from the argument of the *Hughes Property* case. There the government agreed that if a painter painted a taxpayer's house for an agreed amount which was not paid by year-end, and in the following year the painter vanished and never got paid, the taxpayer would still have a deduction in the year the house was painted.* (No. 85-554, Transcript of Oral Argument 23-24.) Obviously, before the time of actual payment, any creditor might go out of business leaving no forwarding address, forgive the debt, or take the check and never cash it, but none of these events would negate the existence at the end of the previous year of a fixed and definite obligation to pay. In short, the possibility that the obligee may not accept payment is always present and does not defeat the deduction.

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* QUESTION: [From The Court] ". . . let's assume a taxpayer who agreed at the end of the year that it owed me $1,000, and then assume further, I just disappeared somewhere and he never had a chance to pay me.

Would that liability have accrued?. . . ."

MR. LAUBER: "It would be proper to accrue the liability, and if you vanished and he never had to pay it, he would then have income in later years. . . . For example, if somebody performed work for you and you agreed to pay that, the painter or the plumber, and you didn't pay them during the year but you are obligated to them, you are an accrual basis taxpayer. Even if the plumber vanished and never got paid, you would get a deduction for a proper accrual in the year you incurred the obligation to pay him." (Transcript 23-24.)

A variation of the government's waiver argument was rejected by this Court in *Hughes Properties*, 106 S.Ct. at 2099:

> There is always a possibility, of course, that a casino may go out of business, or surrender or lose its license, or go into bankruptcy, with the result that the amounts shown on the jackpot indicators would never be won by playing patrons. But this potential nonpayment of an incurred liability exists for every business that uses an accrual method, and it does not prevent accrual. [Citation omitted.] "The existence of an absolute liability is necessary; absolute certainty that it will be discharged by payment is not." *Helvering* v. *Russian Finance & Constr. Corp.*, 77 F.2d 324, 327 (CA2 1935).

Accord, Kaiser Steel Corp. v. *United States*, 717 F.2d 1304, 1306, 1307 (9th Cir. 1983); *Harrold* v. *Commissioner*, 192 F.2d 1002, 1004 (4th Cir. 1951).

As the Tax Court stated in *Buckeye International, Inc.* v. *Commissioner*, 49 T.C.M. 376, 382-383 (1984):

> The Regulation does not require that the taxpayer prove the impossibility of the occurrence of subsequent events that might extinguish or reduce in amount an existing liability. . . . Anytime a debtor incurs liability to make payments in the future, actual payment will be subject to analogous contingencies. Payment can never be certain until actually made. Respondent's interpretation of the regulation thus would virtually eliminate the accrual method of tax accounting.
>
> Respondent's regulation provides a two-part test and clearly distinguishes between the fact of liability and payment on the liability. As long as the liability exists in the year of accrual, uncertainty as to the amount of ultimate payment is irrelevant for purposes of the first requirement of the all events test.

The courts below properly rejected the government's waiver argument.

D. Ministerial Processing Of Claims Did Not Make Taxpayers' Liability Contingent.

While it is true that claims were not paid until processed, this does not mean that taxpayers were not liable for the purposes of the "all events" test until processing was completed. Liability under the plans was contractual (J.A. 25) and complete upon receipt of medical services. Liability was not based in any way whatsoever upon a determination of fault or wrongdoing by taxpayers. (J.A. 25.) No adversary was seeking to impose an unwanted liability on taxpayers. Instead, claims processing was merely a mechanism to calculate the exact amount of a liability taxpayers had already agreed in advance to pay. Claims were processed by the thousands in a routine, repetitive, systematized, clerical procedure. Based on the evidence presented at trial, the trial court correctly concluded that "defendant's emphasis on the claims-processing procedure is misplaced." (Pet. App. 11a.)

While claims processing served a verification function and was the mechanism by which the dollar amounts of the benefit calculations were made, the processing was not a set of "future events" which substantively determined the fact of liability. All of the facts upon which the processors based their calculations had already occurred before the process began and the calculations were not discretionary. The doctor or hospital had been visited, and the services for which payment was due had been performed. The plan of benefits was in effect, so the processor merely had to match the charges submitted against the plans' benefit schedules. Indeed, if the processor were physically at the doctor's office or hospital when the patient left, the calculation of the benefit payment could

have been routinely made on the spot.* Because processing was merely clerical, it by itself was not an event that had to occur for the "all events" test to be met.

A few illustrations will clarify the principles. If a medical benefit plan simply provided that an employee would get $50 for each visit to the doctor and $100 for each day spent in the hospital, it would be obvious to all that the employer's obligation was fixed when the employee went to the doctor or spent a day in the hospital. No one would seriously claim that the obligation was not fixed and definite until a claims processor went over the claim form to add up the number of days in the hospital or check to be sure that the file contained a written confirmation from the doctor of the employee's visit to his office.

Of course, the provisions of the taxpayer's medical benefits plans are more complicated. However, if (as the evidence shows) the provisions are sufficiently specific and detailed so that the benefits can be readily calculated in a routine manner, then the obligation is as definite and fixed as in the simple "$50 per visit to the doctor" example.

Thus, for example, if an employee stays in a semiprivate room in a hospital for three days at a charge of $70 per day and is covered by a medical benefit plan which pays semiprivate room rates up to a maximum of $60 per day, he is, on his discharge, entitled to medical benefits of $180. The claim could be processed routinely in a few minutes. If it were submitted to several different processors, they would reach the same result. Given the terms of the plans,

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* The point of this illustration is that the processing is so routine that a processor could do it on the spot in a few minutes. Hence, the government's argument (Pet. Br. 45-46) that the processor is not actually there misses the point.

the employee's submission of his total hospital bill for $210 (the only bill in his possession) does not amount to a "claim" for $210, and therefore, there is no denial of a "claim" for the additional $30. Under the plan the employee was never entitled to more than $60 a day and, if he had read the plan, he would know it.

Similarly, suppose an employee has an appendectomy operation and the operating physician charges $500. The employee is covered by a basic medical plan which states that it will pay up to $250 for an appendectomy, and a major medical plan, which states that it will pay 80% of the excess over $250 and that the employee will pay the remaining 20%. In this case, immediately following the operation, the taxpayer has a fixed obligation to pay the employee $450 ($250 under the basic plan plus 80% of the remaining $250 of the doctor's bill under the major medical plan). Again, of course, the employee will submit the only bill he has—the doctor's statement for $500. However, in view of the fact that the medical benefit plan clearly provides for payment of $250 plus 80% of the excess over $250, an employee who is familiar with the plan does not expect the entire $500 to be paid, nor will he contest the fact that he has to pay the 20% which is his responsibility under the plan. Again, there is nothing discretionary or problematical about the calculation. If it were submitted to several different processors, each would routinely come up with the same amount. Furthermore, the result does not change depending on the date of submission or processing of the claim.

The government lists four types of situations which it perceives as rendering the liability contingent until processing is completed. As the evidence summarized at pp. 6-9, *supra*, demonstrates, processing is done on a routine basis even in the cases in which these situations are present. Thus, clerical claims processors routinely sort out work-

related injuries, determine if a new employee was treated for a preexisting condition within 90 days before coverage commenced, check the length of a hospital stay to see if it matches their written guidelines or check the size of a physician's bill against their printout to see if it is within the 90th percentile of local charges. Three witnesses testified about these and other aspects of claims processing, and their testimony led the trial court to find that processing was "routine and clerical" and "ministerial in nature." (Pet. App. 12a.)

Given the true nature of claims processing under taxpayers' plans, the Treasury Regulation and relevant cases clearly establish that taxpayers' liability for medical services received in 1972 was fixed by the end of 1972 and that the filing and processing of claims did not change that result. The seminal case articulating the "all events" test, *United States* v. *Anderson*, *supra*, squarely supports taxpayers' position. *Anderson* involved the timing of a deduction for a munitions tax. The tax was based on munitions sold in 1916, but was not assessed, due or payable until 1917. The taxpayer deducted the tax in 1917, but the government asserted that the tax liability accrued before assessment and was deductible in 1916. This Court ruled in favor of the government, stating (269 U.S. at 440-41):

> Only a word need be said with reference to the contention that the tax upon munitions manufactured and sold in 1916 did not accrue until 1917. In a technical legal sense it may be argued that a tax does not accrue until it has been assessed and becomes due; but it is also true that in advance of the assessment of a tax, all the events may occur which fix the amount of the tax and determine the liability of the taxpayer to pay it. . . In the economic and bookkeeping sense with which the statute and Treasury decision were concerned, the taxes had accrued.

The decision in *Anderson* squarely supports taxpayers' deduction in 1972 because here the event which determines the fact of liability was the receipt of medical services. Since *Anderson* found that a step as important as assessment of the tax did not defer the deduction, here the filing and processing of the claim is not necessary to satisfy the "all events" test. Taxpayers' liability for medical expenses is deductible because substantively and practically it has accrued even though payment is not yet due. Relying upon *Anderson*, the trial court correctly held that claims processing was the type of "administrative" or "ministerial" step which does not delay the fixing of liability under the "all events" test. (Pet. App. 12a.)

The decisions below are also consistent with this Court's decision in *Continental Tie & Lumber Co.* v. *United States*, 286 U.S. 290, 295-98 (1932). There an accrual was held to be required currently for an award which had not yet been made and would be made in the future by the Interstate Commerce Commission pursuant to a newly enacted statute. Clearly, claim processing, involving calculations and evaluation, still had to occur before an award was ultimately made. Yet this Court concluded that the Commission's function was ministerial and thus did not preclude accrual.

This Court's decision last term in the *Hughes Properties* case, *supra*, is further support for the taxpayers' deduction. *Hughes Properties* involved the deductibility of the liability for progressive jackpots which were on casino slot machines at year-end. The government opposed deduction on the ground that the progressive jackpots had not yet been won, and it was completely uncertain when in the future they would be won, and by whom. The taxpayer asserted that for all practical purposes the liability was fixed since the state gaming rules precluded taxpayer from reducing the jackpots, and except in remote cir-

cumstances (*e.g.*, going out of business and bankruptcy), the taxpayer would have to pay the jackpot to someone at some time. Relying among other things on *Anderson*, this Court held the liability was fixed for purposes of the "all events" test. It rejected the "speculative possibility" that the jackpots might never be won. The winning pull by the lucky patron was not regarded by this Court as a necessary event to fix the liability at year-end; the last play on the machine fixing the jackpot amount at year-end was sufficient.

The decision in *Hughes Properties* clearly supports taxpayers' deduction in 1972. The receipt of medical services by employees in 1972 fixed taxpayers' liability to them just like the last pull on the slot machine. Since *Hughes Properties* found that the nonoccurrence of a step as important as the winning play on the machine did not preclude deduction, the failure to file claims and/or complete ministerial processing of benefit calculations by year-end should not defeat a deduction in this case. Indeed, the instant case is an even clearer case for the taxpayer. Here, the "winners" of medical benefits existed at year-end. Some had just not stepped up to the window for payment, but when they did, they would have to be paid their contractual benefits. Others had stepped up and would soon be paid.

Other recent cases demonstrate that liability may be fixed for the "all events" test even though payment depends upon events much more significant than the filing of claims and processing of paperwork. One such group of cases involves workmen's compensation liability where state statutes impose no-fault liability for occupational injuries to employees. The workmen's compensation statutes have detailed provisions regarding benefits for medical treatment, lost wages and permanent disability payments. There the issue has been the deductibility of self-

insurance reserves which included amounts for medical services to be rendered in future years and wages which would be lost in future years. Courts in those cases have found that the taxpayer's liability became fixed for the "all events" test at the time the employee was injured and *before* rendition of medical services. Deductions for the reserves were allowed even though they provided for future medical services and future lost wages. *Crescent Wharf & Warehouse Co.* v. *Commissioner*, 518 F.2d 772 (9th Cir. 1975); *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (9th Cir. 1983); *Imperial Colliery Co.* v. *United States*, 599 F. Supp. 653 (S.D.W.Va. 1984).*

Another line of cases supporting taxpayer's position are the strip mining cases. There, taxpayer was engaged in strip mining for coal. By state statute, strip miners had to backfill and restore the land after mining. Mining would commence in one year; the backfilling would be done in a later year. The issue was the deductibility of taxpayers' future costs for future backfilling. The courts concluded that the "all events" test had to be applied in a prac-

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* Contrary to the government's assertion (Pet. Br. 40 n.14), the workmen's compensation cases are not distinguishable from the case at bar. In the workmen's compensation cases, the employee had been injured; here the employees had been to the doctor. There the employee had filed a claim; here some employees had filed claim forms by year-end, yet here the government asserts that processing must be complete. But in workmen's compensation cases future paperwork and processing would be required since future medical benefits and wage claims (for medical services rendered and wages lost in the future) would have to be processed. There the government says liability was conceded; here there is no contest. Furthermore, the future medical bills in the workmen's compensation area would only be paid if properly related to the work-related injury; unrelated, extraneous matters would not be accepted there, just as charges not authorized by the plans are not accepted here. To the extent there are differences, the case for deduction is stronger in the case at bar because the medical services have already been received.

tical way and held that the liability to backfill was fixed and definite when the mining occurred, even though the services to be rendered to backfill the land would be performed in the future. *Harrold* v. *Commissioner*, 192 F.2d 1002 (4th Cir. 1951); *Denise Coal Co.* v. *Commissioner*, 271 F.2d 930, 934-37 (3d Cir. 1959); *Ohio River Collieries Co.* v. *Commissioner*, 77 T.C. 1369 (1981).

The instant case is a stronger and easier one for a deduction than either the workmen's compensation or strip mining cases, where deductions were allowed for services to be performed in the future. Here, the medical services have been performed by the end of 1972. In all of these cases, as in the instant case, there would be paper processing in the future. Bills would come in. Proper charges would be paid; improper ones would not.

E. The Medical Benefit Claims Were Not Contested.

The government further suggests that liability cannot exist until processing is complete because there might be some contested claims. This argument is untenable. The proven fact in this case is that medical benefit claims were not contested. (Pet. App. 12a.) The uncontradicted testimony was that medical benefit claims processing was nonadversarial and did not result in disputes. In ten years there were only *two* lawsuits regarding medical benefits. (J.A. 91, 171-172.) As the trial court found, claims were processed to pay the employees all they were due under the plans. (Pet. App. 12a.) Rather than reject claims, additional documentation was sought so claims could be processed and paid.

To the extent the raw employee medical bills submitted were not paid in full, it was not because of any dispute or contingency, but because the plans, by their terms, only covered most, but not all, expenses (*e.g.*, semi-private

room costs rather than private room costs, major medical paid 80% of costs). Even so, taxpayers actually reimbursed their employees, in the aggregate, for some 90% of all medical costs (covered and not covered) incurred by the employees. (J.A. 91.) There was no showing that properly covered amounts were not paid. The trial court correctly recognized that the 10% of the gross medical bills which were not paid were not entitled to payment under the plan provisions. Thus, there was no nonpayment due to any contest, and the fact that only 90% of gross costs were covered by the terms of the plans did not render the liability contested or uncertain (Pet. App. 12a-13a.).*

Liabilities must actually and affirmatively be disputed to make them contested and thus nondeductible. *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516 (1944). Treasury Regulation § 1.461-2(b)(2) defines "contest" as requiring a "bona fide dispute" and an "affirmative act denying" the liability. (See Addendum.) The Claims Court has ruled that affirmative action denying the liability by the taxpayers is required for a "contest"; mere failure to "acknowledge" liability is not enough. *Hollingsworth, Jr.* v. *United States*, 568 F.2d 192, 198 n.10 (Ct. Cl. 1977). Routine processing procedures, such as those involved here, do not establish any contest. *See, Hershey Creamery Co.* v. *United States*, 101 F. Supp. 877, 884 (Ct. Cl. 1952); *Dravo Corp.* v. *United States*, 348 F.2d 542 (Ct. Cl. 1965); *Japanese Trading Co.* v. *Commissioner*, 25 T.C.M. 441 (1966). The government's speculation about nonexistent contests is the type of remote and speculative possibility which this Court refused to countenance in *Hughes Properties*.

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* In any event, the taxpayers were accruing only for the amounts actually covered by the plans, not for excess portions of bills which were not covered. (Tr. 147, 229.) Consequently, they are entitled to the deduction. Treasury Regulation § 1.461-1(a)(2) specifically allows deduction of any "undisputed" amount or portion.

F. Payment Did Not Have To Be Presently Due.

By its staunch resistance to a deduction for existing liabilities which will be paid in a future year, the government really seeks to impose upon these accrual-basis taxpayers the cash basis of accounting for these expenses. Under the government's view, it will not be satisfied until payment has actually been made or is ready to be made. In other words, it is the very nature of accrual accounting to which the government objects.

In its brief, the government confuses the matter of having a liability to someone (although perhaps payable at a later date) and having a liability for which payment is presently due. The "all events" test requires the former, but it definitely does not require that such obligation be presently due and payable. *United States* v. *Anderson, supra* (the munitions tax deductible in 1916 was not due and payable until 1917); *American National Co.* v. *United States*, 274 U.S. 99 (1927); *Brown* v. *Helvering*, 291 U.S. 193 (1934).

This Court's recent *Hughes Properties* decision quoted with approval (106 S.Ct. at 2099) the following language from *Helvering* v. *Russian Finance & Construction Corp.*, 77 F.2d 324, 327 (2d Cir. 1935):

> "The existence of an absolute liability is necessary; absolute certainty that it will be discharged by payment is not."

In *Hughes Properties* the jackpot liability which was deducted was an amount listed on a machine which no one had won yet. The government's basic argument was that there was no liability until the lucky player won. It was concerned that there was no existing obligee who could enforce any liability. This Court held that the winning play was not a prerequisite for liability for the "all events" test. Clearly, until the winning play occurred in

the future, the casino had no present obligation to pay anyone. In the instant case, since employees have received medical services prior to year-end, obligees who can enforce the liability exist. That payment is not due them until the mechanics of claims processing are complete should not, on the basis of *Hughes Properties*, preclude liability under the "all events" test.

G. Taxpayers Did Not Need To Know The Identity Of The Benefits Recipients At Year-End.

The government also argues that liability is not fixed because taxpayers did not actually know the precise identity of all the employees who had received medical services by year-end and the amounts of each claim. Of course, taxpayers did know the names of those employees who had submitted forms which were undergoing processing. While taxpayers did not have this knowledge for those employees who had not yet filed claims, this fact is irrelevant, and it does not transform a fixed liability into a contingent, nondeductible item.

The liability at issue here is not for services to be performed in the future for employees whose identity will be determined by future events. (Tr. 146, 228-229.) Here the liability was fixed because at the end of 1972 services had in fact been received by specific identifiable persons who were members of a fixed group: taxpayers' covered employees and their eligible dependents. The taxpayers did not actually know all of the names since they had not collected this information. But since the medical services had been received, the liabilities were fixed, and the identities of the specific people were knowable. The taxpayers could have canvassed all of their employees in December of 1972 to ascertain who had claims for medical benefits which had not yet been filed. This is sufficient. As stated

by the court in *Uncasville Mfg. Co.* v. *Commissioner*, 55 F.2d 893, 895 (2d Cir. 1932),*

> All the facts upon which the calculation depended had been fixed before the expiration of the year 1918. . . . The computation was uncertain, but its basis was unchangeable; it was unknown, not unknowable on December 31, 1918. That is the test. . . .

Indeed, since the claimants were knowable, taxpayers more than satisfied the legal requirements. A number of cases establish that taxpayers did not need to have a roster of the actual names of all persons receiving medical services in 1972—even if the identities of those persons had been not only unknown but also unknowable. In *Hughes Properties*, *supra*, the government's argument that the winning jackpot player's identity was required was rejected.

> The Government misstates the need for identification of the winning player. That is, or should be, a matter of no relevance for the casino operator. The obligation is there, and whether it turns out that the winner is one patron or another makes no conceivable difference to the basic liability. 106 S.Ct. at 2097.

In *Hughes Properties*, since no one had in fact won the jackpot, the identity of the winner was not only unknown but unknowable, yet that was sufficient. But in the instant case, specific employees had actually been to the doctor by year-end, so their identities, although not known were knowable because taxpayers could have canvassed their 56,000 employees. These employees who had received services existed and would not change. Indeed, at the oral argument in *Hughes Properties*, the government

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* *Uncasville* is an opinion by Judge Learned Hand, which was cited with approval by this Court in *Brown* v. *Helvering*, 291 U.S. at 200 n.6 (1934).

conceded that knowledge of the identity of the obligee is not required by the "all events" test.* (No. 85-554, Transcript of Oral Argument 11-12.)

In *Washington Post Co.* v. *United States*, 405 F.2d 1279 (Ct. Cl. 1969), the issue was whether the taxpayer (a newspaper) could deduct the amount entered on its books as due under a profit-sharing arrangement for its dealers. No money had actually been set aside or paid out to a third-party custodian. There were individual accounts for dealers, but the dealers were not vested in certain portions of the account balances, which amounts could be forfeited. Thus, the ultimate recipients as well as the time of payment and amount of payment were unknown at year-end, and indeed unknowable. The Court of Claims rejected defendant's argument that these uncertainties made the liability contingent, and the full deduction was allowed. The court, taking a practical view of the situation, concluded that the amount which was to be paid in total was fixed and the uncertainties as to specific people, payouts, etc., did not make the liability any less real, fixed or certain. The Court stated: "the 'all-events' test . . . is not inflexible; when the liability itself is clearly fixed, as in this case, other uncertainties do not necessarily destroy that initial certainty." 405 F.2d at 1284.

In *Lukens Steel Co.* v. *Commissioner*, 442 F.2d 1131 (3d Cir. 1971), the taxpayer was to make payments to a

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* QUESTION: [From the Court] "Why should the identity of the eventual payee matter, as long as it's certain there will be a payee? . . ."

MR. LAUBER: "Well, I would agree with the premise that the ultimate identity of the payee is not important. But we think what precludes the deduction here is that nobody has won the jackpot. It's not that someone has won and we don't know who. . . ." (Transcript 11-12.) Here, someone has won, yet the government's objection is that "we don't know who."

trust fund under a supplemental unemployment benefit plan for laid-off workers. Part of the payment was currently paid in cash; the balance was merely accrued on taxpayer's books. It was unclear when the accrued balance would be paid to the trust. Under the plan, it was also impossible to determine which employees would receive benefits, since payments would be made for layoffs in the future. The court held that the liability to pay the accrued amount to the plan in the future was sufficiently fixed and certain to be presently deductible. *Accord, Inland Steel Co.* v. *United States*, 212 Ct. Cl. 558 (1976).

Lukens Steel was relied on by the Tax Court in *Ohio River Collieries*, one of the strip mining cases. The Tax Court stated: "The fact that the recipients of petitioner's reclamation payments and the relative portions that they would receive were not identified in the tax year is irrelevant." 77 T.C. at 1375. In stark contrast to the case at bar, those recipients could not be known in the tax year since the reclamation services had not been rendered.

From the foregoing cases, it can be seen that deductibility of the accrued liability for services received is not precluded by the fact that taxpayers did not know exactly which of its employees covered by the plans had received the benefits.* The trial court's rejection of defendant's argument on this point was correct. (Pet. App. 14a-15a.)

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* This lack of knowledge did not last long. Most claims for 1972 liabilities came in early in 1973 and, except for very minor amounts, were promptly processed and paid in 1973. (J.A. 35, 93.) Thus, the government's contention (Pet. Br. 36 n.11) that taxpayers were not obligated to pay claims more than two years old has no real application to the actual facts.

H. The Government's Cases Are Inapposite.

The government seeks to buttress its claim that taxpayers must have a claim filed and processed for each employee before year-end on the theory that otherwise taxpayers are impermissibly attempting to deduct a future, contingent liability based solely on their ability to predict future liabilities. This is a distortion of the taxpayers' position.

Taxpayers in this case are not attempting to deduct future, contingent liabilities based on the premise that they are able to estimate the amount with reasonable accuracy. They are not seeking to deduct in 1972 the amount of medical expenses to be incurred in 1973 for services received in 1973 on the theory that they can reasonably estimate what that amount will be. Instead, taxpayers are seeking a deduction for existing liabilities for services received in 1972. These services had already been received by specific individual employees, which is all that is required. The events fixing liability had already occurred. The government's cases on this point are all clearly beside the point because they involved contingent or contested liabilities and this case does not.

Thus, *Brown* v. *Helvering*, 291 U.S. 193 (1934), involved a proposed deduction for commission refunds which might have to be made by an insurance agent if policies were cancelled in the future. This is a typical situation of a contingent liability which might arise depending upon the occurrence of future events (there, the cancellation of policies). The fact that the taxpayer could reasonably estimate the amount of future cancellations could not eliminate the requirement that a fixed liability presently exist to satisfy the first part of the "all events" test.

In *Hughes Properties, supra*, this Court found that the government's "heavy reliance" on *Brown* v. *Helvering* was "misplaced" (106 S.Ct. at 2097-2098):

> because the actual event that would create the liability—the cancellation of a particular policy in a later year—'[did] not occur during the taxable year' . . . but rather occurred only in a later year in which the policy was in fact cancelled. Here, however, the event creating liability . . . was the last play of the machine before the end of the fiscal year, since that play fixed the jackpot amount irrevocably.

Similarly, in the instant case, as discussed above, the trip to the doctor or hospital fixed the amount of the medical benefits, and the medical benefits for which deduction is sought are only those which were received in 1972.*

American Automobile Ass'n v. *United States*, 367 U.S. 687 (1961), concluded that the taxpayer, an automobile club, could not defer membership income which it had already received on the ground that it would be required to provide services to members upon request over a future period of time. The taxpayer tried unsuccessfully to persuade the Court to allow such a deferral based on the claimed accuracy of its estimates of when and in what amounts future membership service would have to be provided. This was, of course, a contingent matter dependent upon the occurrence of future events. The events causing members to request service had not yet occurred, and the members had, therefore, not requested service. Consequently, the deferral of income was properly rejected.**

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* In *Brown*, the cancellation was necessary to fix the liability. Of course, even after a cancellation notice came in, processing would have to occur to determine pursuant to the policy the correct amount of the refund according to the terms of the policy. There is no suggestion in *Brown* that the liability would await not only cancellation but also subsequent processing. The ministerial processing which occurred in this case serves the same function, and has the same lack of significance.

** The government's other cases also involve contingent, future liabilities. In *Trinity Construction Co.* v. *United States*, 424 F.2d

(Footnote continued on following page)

In each of these cases, the taxpayers attempted to deduct a liability or defer income to match expenses which would not arise until the occurrence of contingent future events (*e.g.*, the cancellation of policies or the demand for services by customers) on the theory that they could accurately estimate the amount that those liabilities would add up to when they did accrue. In short, the taxpayers were trying to use their claimed ability to satisfy the second "reasonable amount" prong of the "all events" test to bypass the first "fixed liability" prong. Those arguments were rejected because the existence of a fixed liability is required before the amount issue could be reached.

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footnote continued

302 (5th Cir. 1970), an employer was obligated to pay premiums on life insurance policies for certain employees but only if the particular employee was alive when the premium was due. In *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983), a company was obligated to pay bonuses in later years, but only if the employee was still employed when the payment came due. In *World Airways, Inc.* v. *Commissioner*, 62 T.C. 786 (1974), *aff'd*, 564 F.2d 886 (9th Cir. 1977), the taxpayer had an obligation to perform and pay for overhauls on airplane engines and frames in the future, but only if the airplanes continued in service long enough to log enough flight hours so that the overhaul was in fact due. Furthermore, the taxpayer had contracted with third parties to perform the overhauls, and the taxpayer was only liable to pay for overhauls actually performed. Each of these cases is inapposite to the instant case. In each of these cases, a future event had to happen before any underlying liability came into existence. That is not the case here. Once the employee had been to the doctor and received the medical services, the underlying liability attached. All that remained to be done was the clerical process of calculating the amount of the payment under the terms of the plan. The employee did not have to survive and be living as of the payment date, as in *Trinity Construction*. Nor did he have to continue in taxpayers' employ until payment, as in *Bennett Paper*. The medical services had already been rendered and received by year-end. Taxpayers are not trying to deduct in 1972 an estimate for medical services to be performed in later years, as was, by analogy, the situation in *World Airways*.

In *Milwaukee & Suburban Transport Corp.* v. *Commissioner*, 18 T.C.M. 1039 (1959), *rev'd*, 283 F.2d 279 (7th Cir. 1960), *vacated and remanded*, 367 U.S. 906 (1961), *aff'd on remand*, 293 F.2d 628 (7th Cir. 1961), the claims at issue were personal injury and property damage claims (tort claims), which were contested. As such, according to well-established authority,* they could not satisfy the first part of the "all-events" test. Furthermore, the amount of the liability also depended on the outcome of the contest. The government's extended discussion of this case (which has a confusing history) is irrelevant since this case is inapposite to the instant case where the medical benefits were uncontested contractual liabilities.

Similarly, *Lucas* v. *American Code Co.*, 280 U.S. 445 (1930), is inapposite as the government's own description of the case shows. (Pet. Br. 17, 39.) *Lucas* involved a contested liability for breach of contract which was in active litigation and the amount of which depended upon the outcome of the lawsuit.

Finally, the government's "aggregate estimate" objection is really a quarrel with the method taxpayers used to determine the amount of their liability. Neither the regulations, nor the cases prescribe any particular method of calculation or condemn a particular calculation because it is made on an aggregate rather than individual-by-individual basis. Consequently, the lower courts were correct in holding that the second prong of the "all events" test had been satisfied. In this Court, however, the short answer to the Government's argument is that the "amount" issue is foreclosed because the Government decided not to seek review of that issue. (Pet. 13 n.2; Pet. Br. 33 n.10.)

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* *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516 (1944).

II. THE GOVERNMENT'S RED HERRINGS.

Based on the trial evidence, both courts below found that taxpayers satisfied the general rule applicable to all accrual-basis taxpayers: the "all events" test. In this Court, the government directs the first part of its brief to a series of irrelevant arguments, delaying to page 30 its discussion of the "all events" test, the only issue properly before this Court. Regardless of the prominence given to these irrelevancies in the government's brief, however, they are still red herrings in this case.

Reserves. The government argues at length that no "reserves" are proper deductions unless explicitly allowed by the Internal Revenue Code. Reduced to the essentials, the government's position is: call it a "reserve" and the government wins. Of course, that is not true.

The government's underlying premise—that all reserves necessarily constitute contingent, future liabilities—is simply fallacious. A reserve is merely an accounting device to make provision for a liability which has not yet been paid—any kind of liability. A reserve may be set up for a contingent liability. But a reserve may also be set up for a fixed and certain liability, *e.g.*, a fixed liability to pay X dollars on March 15th of the next year. The "all events" test issue is whether the liability reserved for is fixed or contingent, not what label is attached to the accounting entry.* Certainly, a taxpayer cannot be denied

* The government asserts that taxpayers admit that the reserves used here were "garden variety" reserves and that self-insurance reserves are generally not deductible. (Pet Br. 30.) In fact, taxpayers have admitted none of these things but have merely declined to discuss irrelevant issues. The relevant question is the nature of the liability (in this case, fixed and definite) rather than the fact that a reserve has been established or the mechanics of reserve accounting.

a deduction for a fixed liability simply because he set up a reserve for it.

Cases such as *Commissioner v. Hansen*, 360 U.S. 446 (1959); *Brown v. Helvering*, *supra*; and *Lucas v. American Code Co.*, *supra*, cited by the government, do not support the proposition that all reserves are nondeductible. The government's own description of these cases (Pet. Br. 17) shows that they involved contingent or contested future liabilities, liabilities which did not satisfy the "all events" test.* Moreover, numerous cases show that the government's "label-it-a-reserve-and-I-win" position is erroneous. In *Anderson*, *supra*, the seminal "all events" case, this Court held that a "reserve for taxes" was deductible. In the workmen's compensation and strip mining cases discussed above, "reserves" labeled as such were at issue and were held to be deductible.

The Tax Court in *Buckeye International*, *supra*, exhibited a keen insight into the real significance of this type of government argument (49 T.C.M. at 385):

> [The Commissioner] raises several arguments which indicate his dissatisfaction with the accrual method of tax accounting. [The Commissioner] asserts, for example, that [the taxpayer] has attempted to deduct

* The government's cases which merely describe the mechanics of reserves (Pet. Br. 16 n.2.) obviously do not constitute authorities against a deduction. Furthermore, the government's lengthy (Pet. Br. 4-6, 24-25) and inaccurate (see J. A. 27-32) description of the history of taxpayers' reserve is also irrelevant to the issue before this Court. Satisfaction of the first prong of the "all events" test does not turn on whether taxpayers had been insured for the medical benefits and then switched to self-insurance, or had started the benefits plans fresh with no history of insurance; nor does it turn on whether the insurance companies returned money to taxpayers because taxpayers had assumed the outstanding liability for unpaid claims from the prior insured period, or whether taxpayers had set up an entirely new reserve on December 31, 1972.

> a reserve and that "[i]n the absence of specific statutory authorization, federal income tax deductions for reserves for future liability are not permitted." We agree that a taxpayer may not deduct estimated future expenses for which liability does not exist. [Citation omitted.] Nowhere does [the Commissioner] define the term "reserves," however. Simply using the term to describe the deductions in issue is insufficient. . . . Where, as in the current case, the liability in question satisfies both requirements of the all events test, accrual is proper despite the label used by [the Commissioner].

Financial Accounting. It is true, as the government states at length, that financial accounting, premised on principles of conservatism, may require reserves for contingent or contested liabilities which are not allowed for tax accounting purposes (because contingent and contested liabilities are not deductible under the "all events" test); but that is also irrelevant to this case. Taxpayers have not sought to justify their deduction on the ground that it accords with proper financial accounting principles, although they believe that it does. No evidence on financial accounting was introduced or relied upon. Instead, the taxpayers have always recognized and presented their case on the admittedly controlling issue—whether their liability is a fixed and certain liability which satisfies the "all events" test. Certainly no taxpayer has been denied a deduction for a fixed liability merely because making provision for that liability also happened to be in accordance with financial accounting principles. A similar "financial accounting is not tax accounting" argument based on the same government authorities was found to be "unpersuasive" by this Court in *Hughes Properties*, 106 S.Ct. at 2098.

Repeal of Section 462. The government makes an argument based on the repeal of Section 462 of the Internal

Revenue Code, which would have allowed the deduction of certain reserves for expenses which otherwise would have been required to be deducted in a later year. The government argues that this repeal somehow establishes that taxpayers' reserve for a fixed liability which satisfies the "all events" test is not deductible. This argument is wrong, as this Court found in *Hughes Properties*.

> The fact that Congress once briefly adopted statutory provisions that specifically would have permitted a taxpayer to deduct anticipated expenses by a reserve mechanism is hardly significant. 106 S.Ct. at 2098 n.4.

If the liability is fixed, it was deductible before and after repeal of Section 462.

Insurance. The government argues that, since insurance companies are subject to specific Code provisions which allow deductions for reserves, taxpayers, which are not insurance companies, cannot deduct their reserve for 1972 medical expenses. (Pet. Br. 26-29.)

Again, this argument is wholly beside the point. Insurance companies are permitted to deduct all kinds of liabilities including many which are contingent or contested. Indeed, the reserves of casualty companies which cover situations such as injury claims from auto accidents are composed largely of estimated amounts which will be due only after the resolution of contested claims.

But taxpayers have never argued that they are entitled to the benefit of the Code sections applicable to insurance companies. They have never argued that they are *de facto* insurance companies. They have never claimed the right to deduct contingent or contested liabilities. Consequently, it does not matter whether (as the government argues) "self-insurance" is a misnomer because no insurance is involved. The government cites no case that has held that

the existence of the special insurance company provisions means that a liability which meets the "all events" test—the test applicable to ordinary taxpayers—cannot be deducted by those ordinary taxpayers.*

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* The "self-insurance" cases cited by the government all involved liabilities which were contingent on future events or contested. Since deductions of such liabilities could not be justified on the basis of the "all events" test, the taxpayers in those cases set up captive or wholly-owned insurance companies and then sought deductions for the payments made to these companies as deductible insurance premiums under Section 162 of the Code. The courts disallowed the deductions on the basis that they represented nothing more than additions to a self-insurance reserve set up to cover the future contingent liabilities at issue.

The government cites *Bituminous Casualty Corp. v. Commissioner*, 57 T.C. 58 (1971), for the proposition that "the deduction of casualty insurance reserves by ordinary accrual-basis taxpayers is 'fundamentally at odds with the all events test.' " (Pet. Br. 30-31.) In fact, the Tax Court's holding was that it would be unfair to limit insurance companies to deductions authorized by the "all events" test. In the passage quoted by the government, the Court pointed out that the particular reserves sought to be deducted could not qualify under the "all events" test because the liabilities were either contested or contingent on future events. The Court's statement in context is as follows (57 T.C. at 77):

> "The deduction of these loss and loss adjustment expense items is fundamentally at odds with the 'all events' test: the items include amounts for liabilities which are not established, but, on the contrary, vigorously contested; they include, in the case of the loss adjustment items, expenses which will not only be paid in the future, but which are attributable to events which will not occur until the future, including future overhead. . . . "

CONCLUSION

For all of the foregoing reasons, the judgments of the United States Claims Court and the United States Court of Appeals for the Federal Circuit should be affirmed.

Respectfully submitted,

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ADDENDUM

Treasury Regulation § 1.461-2(b)(2): "Any contest which would prevent accrual of a liability under Section 461(a) shall be considered to be a contest in determining whether the taxpayer satisfies paragraph (a)(1)(i) of this section. A contest arises when there is a bona fide dispute as to the proper evaluation of the law or the facts necessary to determine the existence or correctness of the amount of an asserted liability. It is not necessary to institute suit in a court of law in order to contest an asserted liability. An affirmative act denying the validity or accuracy, or both, of an asserted liability to the person who is asserting such liability, such as including a written protest with payment of the asserted liability, is sufficient to commence a contest. Thus, lodging a protest in accordance with local law is sufficient to contest an asserted liability for taxes. It is not necessary that the affirmative act denying the validity or accuracy, or both, of an asserted liability be in writing if, upon examination of all the facts and circumstances, it can be established to the satisfaction of the Commissioner that a liability has been asserted and contested."